Health and Social Care Select Committee Inquiry: Safety of Maternity Services in England

A response from the Association of Personal Injury Lawyers (APIL) – September 2020

Responsibility for safety

Responsibility for the safety of maternity services lies solely with the NHS, but APIL and its members are keen to continue to work in partnership to do what we can to help improve safety. Previously, we have had discussions with representatives from NHS Resolution, including chief executive Helen Vernon, to see where we can work together to improve outcomes for injured people and their families. Earlier this year, for example, we met with NHS Resolution to discuss maternity claims.

We recognise the work which has been undertaken by the NHS to improve the safety of maternity services. This has included work to speed up investigations into what went wrong in individual maternity cases and encourage learning, through both the Early Notification Scheme (ENS) and the Healthcare Safety Investigation Branch (HSIB). When it launched this inquiry, the committee noted that there has been a 'substantial amount of work carried out in recent years to improve maternity safety'[1]. It is clear, however, that more needs to be done to ensure a consistent approach to learning from mistakes at individual NHS Trusts across the country.

The role of litigation

Our members are there to pick up the pieces after a tragedy, but we would all prefer for that tragedy not to happen in the first place. Childbirth should always happen in a safe environment with a positive outcome for parents and children.

[1] https://committees.parliament.uk/committee/81/health-and-social-care-committee/news/147553/mps-call-for-evidence-on-maternity-safety-and-what-more-must-be-done-to-improve-it/

When something does go wrong in maternity services it is devastating for all concerned. For some families, what is supposed to be the happiest of occasions becomes the worst thing which will ever happen to them. Their lives will be turned upside down. The mother will not be prepared for what has happened, and hardly anyone will be able to appreciate the traumatic situation she and her family will be going through.

The committee's call for evidence asks about the contribution of clinical negligence and the litigation process to maternity safety, and what changes could be made to those processes to improve the safety of maternity services. The role of litigation is to try to put people's lives back together after they have been harmed when they should not have been harmed. It is about restoring some quality of life to those whose lives and futures may have been shattered. Of course, litigation also contributes to the highlighting of failures within maternity services and, in turn, provide learning opportunities. Only the NHS, however, has the ability to learn from those failures.

There must be confidence that an NHS Trust has recognised what has gone wrong, accepted that changes need to be made and, more importantly, that changes will actually be made. It cannot simply be enough for NHS Trusts to say "this will never happen again", when all too often our members find that it does happen again.

Increased transparency and accountability

The NHS has made great strides to increase openness and transparency, but there is still more that can be done. The introduction of a duty of candour, for example, was a welcome development. As part of the duty of candour, staff must tell the patient when something has gone wrong, apologise, and explain the short and long-term effects of what has happened. It is the experience of our members, however, that the duty of candour is not always being adhered to by healthcare practitioners.

Transparency is a key factor in ensuring that NHS Trusts learn from their mistakes on a consistent basis.

To that end, we recommend the creation of a national, public, NHS learning and improvement database. Currently, learning opportunities and recommendations for improvements can be identified as part of the litigation process, internal or external reviews, or investigations by HSIB. A lack of public follow-up and transparency can make it difficult to see how effective those recommendations have been, or even if they have been implemented at all. Our members and the injured people they serve are too often left frustrated by learning opportunities that have been missed, and recommendations for improvements which appear to simply be left to gather dust.

Such a database, with an emphasis on transparency, available for public scrutiny, would help to ensure consistency in learning outcomes across all NHS Trusts and help to prevent the catastrophic consequences of lives lost or ruined because systemic failings have apparently not been noticed or recognised.

It would also help to provide confidence to families. The confidence of expectant parents may have been severely shaken because of reported widespread problems at NHS Trusts in Morecambe Bay, Shrewsbury and East Kent, or by individual issues within their local NHS Trust. They will want the confidence that lessons have been learned, and the same thing will not happen to them. It would be hard to imagine any NHS Trust would want recommendations or learning opportunities identified on a public database not to be implemented as quickly as possible. From this database, it would also be possible to identify if the same failures were happening in either the same NHS Trust, or across the wider NHS, allowing immediate appropriate and consistent action to be taken.

Transparency is vital to improve safety, but there must also be accountability to ensure that recommendations are implemented. Connected to the database, therefore, would be new public action reports. These reports, which would be accessible as part of the database, would provide a timescale for evaluation of the action taken to improve services. This evaluation would be carried out by an external organisation, and not internally by the NHS Trust.

Public recommendations to improve services which could save lives are not unusual. Coroners, for example, can make recommendations after avoidable deaths to improve public health, welfare and safety. These recommendations are publicly available. A national learning and improvement database for the NHS, while not just focusing on incidents which result in the loss of life, would be no different.

Importance of learning

This year an independent investigation was launched into maternity and neonatal services provided by East Kent Hospitals University NHS Foundation Trust. Concerns about the safety of maternity care at the Trust's Queen Elizabeth, the Queen Mother, Hospital (QEQM) in Thanet had already prompted a review by the Royal College of Obstetricians & Gynaecologists (RCOG) in 2015. In particular, the review found there were concerns about the failure of three to four consultants at QEQM to "conduct daily ward rounds, review women, make plans for care and attend when requested out of hours".

It also highlighted a poor safety culture, as staff felt there was little point in raising concerns because no action would be taken by the Trust [2]. The review's report included 23 recommendations for improvement.

This year there was a review of those 23 recommendations which found that "there was sufficient evidence that two recommendations had been met, that 11 had been partially met".[3]

More than a year after the RCOG report was sent to the Trust in February 2016, the same failings reported by the RCOG were repeated in the case of Harry Richford, who died aged 7 days old on 9 November 2017[4]. The NHS Trust had not learned from the mistakes which resulted in the RCOG review. The coroner at the inquest into the death of Harry Richford found seven failings, including the absence of experienced staff[5].

An internal review of the implementation of the recommendations following the RCOG review was launched only after the inquest into the death of Harry Richford[6]. This is unacceptable. It should never have taken the death of another baby to check if recommendations from a previous safety review had been implemented. Furthermore, the chief executive of East Kent Hospitals University NHS Foundation Trust, who joined the Trust on 1 April 2018, has admitted she did not even read the RCOG report until December 2019[7]. This report highlighted serious failings, not least about staff who felt there was no point raising safety concerns. What must have gone wrong in that NHS Trust to result in a new CEO not reading that report until 20 months after she had taken up her post?

Changes to the clinical negligence and litigation processes would not have improved services at East Kent. If a national database had been in place, and recommendations from the RCOG review had been on it, showing clearly whether or not they had been implemented, services at East Kent may have improved. Certainly, it would not have taken an internal review after the death of a baby to provide an update on implementation.

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[2] Royal College of Obstetricians & Gynaecologist, REPORT, Review of Obstetrics and Gynaecology Services at East Kent Hospitals University NHS Foundation Trust, On 24, 25 and 26 November 2015. The report is available in a response to a Freedom of Information request here https://www.ekhuft.nhs.uk/patients-and-visitors/about-us/freedom-of-information/foi-disclosure-log/?entryid164=463008&q=0%7ERCOG%7E

[3] Final Report from the Learning and Review Committee (LRC), report to the Board of Directors, East Kent Hospitals University NHS Foundation Trust, 16 July 2020, page 1

[4] http://harrysstory.co.uk/

[5] http://harrysstory.co.uk/the-inquest.html

[6] https://www.bbc.co.uk/news/uk-england-kent-53406534

[7] https://www.bbc.co.uk/news/uk-england-kent-51479860

Continued public scrutiny

From the very moment an expectant mother is told she is pregnant, every single person with whom she comes into contact in the NHS has their own part to play to keep her and her child safe. If this is not happening, staff should have the confidence to raise concerns at the highest level within the NHS Trust without the threat of any type of reprisal. A recent report from the Institute for Public Policy Research (IPPR) on the issue of injury prevention refers to this as a '360 degree' approach, "whereby everyone is equally empowered to halt unsafe activity, regardless of age or job role".[8]

The NHS is a beloved institution, staffed by hard-working and dedicated people. Most of us will have benefited from perfectly safe NHS services, but that does not mean that we should ever allow the NHS to be exempt from public scrutiny. Only by increased transparency and consistency, holding NHS Trusts to account on each and every recommendation made to improve safety, can we have the confidence that lessons will be learned, and no other family has to suffer needlessly.

About APIL

The Association of Personal Injury Lawyers (APIL) is a not-for-profit organisation which has worked for 30 years to help injured people gain the access to justice they need, and to which they are entitled. We have more than 3,100 members who are committed to supporting the association's aims, and all are signed up to APIL's code of conduct and consumer charter. Membership comprises mostly solicitors, along with barristers, legal executives, paralegals and some academics.

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[8] Better Than Cure, Injury Prevention, IPPR, August 2020, page 13, https://www.ippr.org/files/2020-08/better-than-cure-august-20.pdf